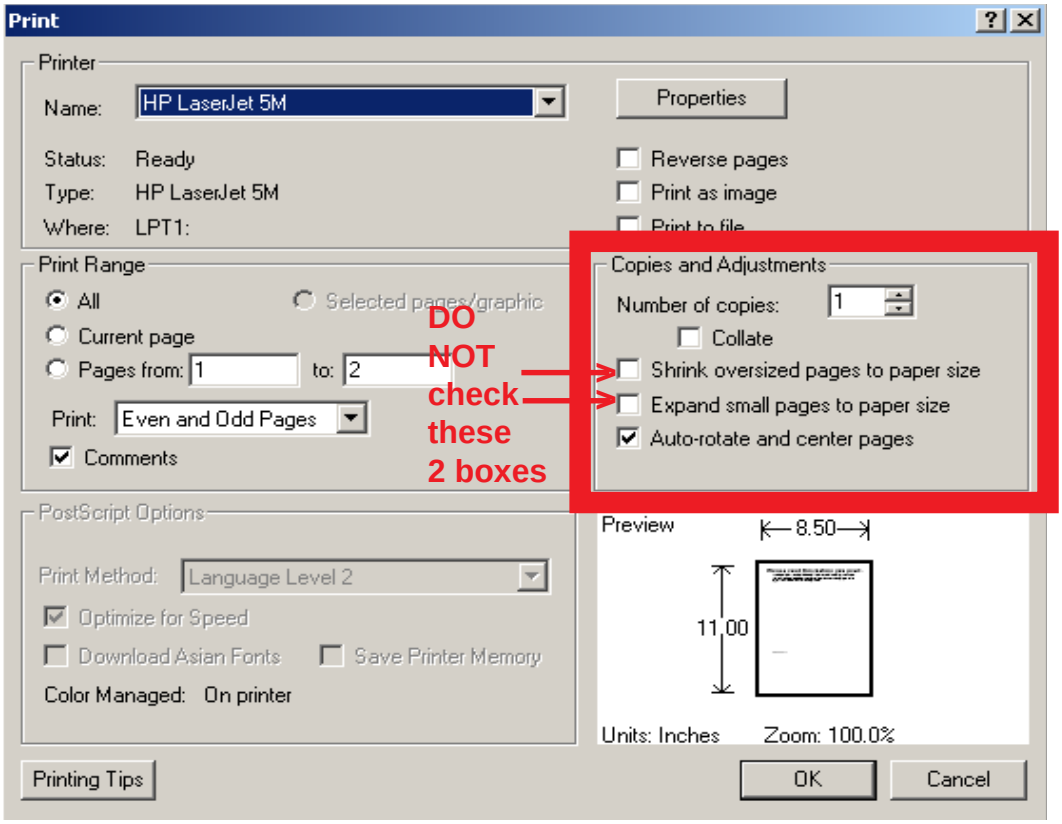
Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or Expand boxes.



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Health Professions Quality Assurance
P.O. Box 47869
Olympia, WA 98504-7869

A. Contents:

Inactive Osteopathic Physician and Surgeon Credential Activation Application Packet

B. Important Social Security Number Information:

* Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.
* Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099**.

Cut along this line and return the form below with your completed application and fees.

Osteopathic Physician and Surgeon
(Inactive)

DEPOSIT SLIP

NAME (Please Print)

DATE

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

Please note amount enclosed, and return with your application.

$

☐ **Check**
☐ **Money Order**

DOH 663-058 (REV 6/2004)

1F 0252070000 00420

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Instructions For Credential Activation
Inactive Osteopathic Physician and Surgeon

Attached is the application packet for your Washington State Credential. When your application for inactive Osteopathic Physician and Surgeon credential activation is received by the Department of Health, Board of Osteopathic Medicine and Surgery, you will be sent an acknowledgment letter noting receipt, and any outstanding documentation needed to complete the process.

To ensure that you have submitted the necessary fees and documentation, we encourage you to use the following checklist:

☐ Pay **$ 500.00** in total fees. **(All fees are non-refundable)**

☐ ***Box #1: Demographic Information:***

Name: Please list your current name with middle initial.

Residential Address: Please identify the address to which you wish all correspondence, including your credential, delivered. This will become your address of record for all Department of Health transactions until we are notified of a change.

Telephone Number: Enter current number where you may be reached during normal business hours.

Social Security Number: Required for licensure under 42 USC 666 and Chapter 26.23 RCW.

Additional Data: This information is required to update the Department's Database, and confirm information from your previous (initial) application.

☐ ***Box #2: Previous Credentialing*.** List ***all*** credentials you have held since last being credentialed in Washington State. List in chronological order, most current first. Include your last active credential in Washington State. If you need additional space, attach on a separate piece of paper.

☐ ***Box #3: Professional Experience.*** In chronological order, list all professional work experience since your Washington State credential has expired. Please identify all time breaks of 30 days or more. If you need additional space, attach on a separate piece of paper.

☐ ***Box #4: AIDS Education and Training Attestation.*** Required by WAC 246-12-040.

☐ ***Box #5: Disciplinary Action Attestation.*** Required by WAC 246-12-040. This section pertains to formal or informal disciplinary action by any regulatory authorities, hospitals, state or federal jurisdictions, criminal convictions, and civil judgments connected with the practice of medicine. If you are unable to attest that you have not had action, please provide a synopsis of the situation, as well as the appropriate supporting documentation.

☐ ***Box #6: Continuing Education Attestation.*** Required by WAC 246-12-040 and 246-853-060, 246-853-070, 246-853-080, and 246-853-090.

☐ ***Box #7: Hospital Privileges.*** Please list in Section #7 those hospitals where privileges have been granted in the past five years.

☐ ***Box #8: Applicant's Attestation.*** Required to be signed and dated in order to process the application. Please read thoroughly to ensure your understanding of the provisions in this section.

Additional Documentation Required For Activation.

☐ ***Professional Liability Action History.*** Malpractice information pertaining to any civil suit or judgment in connection with the practice of a health care profession. Include the nature of the case, date and summary of the care given, and settlement amount. The applicant must provide a separate summary of each case, and include copies of the settlement or final disposition. If pending, indicate status. If the case is rather old, you should be able to contact the county where it was filed to get the documentation. *Please attach on a separate piece of paper.*

☐ ***State Licensure Verification.*** Applicants must verify all osteopathic medical licenses that he or she holds, or has held, in any other state, territory or possession of the United States or Canadian province since the expiration date of your previous Washington State credential. Verification is required whether the license is active or inactive. This includes temporary and training licenses. Applicants should contact the state licensing authority for information regarding fees for verification of licensure. *Form provided.*

☐ ***Hospital Privileges.*** Applicants must verify all hospitals where admitting or specialty privileges have been granted in the last five (5) years. Verification must be received directly from the hospital. All hospital privileges connected with military practice experiences may be verified by the current duty station or, if no longer in active service, the appropriate agency of record or National Personnel Records Center, (Military Personnel Records), 9700 Page Boulevard, St. Louis, MO 63132. *Form provided.*

☐ ***Federation of State Medical Boards Data Bank Clearance.*** The Board requests verification of any disciplinary actions directly from the Federation.

☐ ***American Osteopathic Association Physician Profile.*** The Board requests education and training profiles directly from the AOA.

The process of re-activation will involve retrieval of your previous credential file from the state records center. The retrieval time period is approximately two (2) weeks. Pursuant to WAC 246-853-025 a reactivation applicant may be required to take a special purpose examination.

Once the abbreviated application is considered complete, it will be referred for review. All information, documents data, etc., provided to the Department by the applicant is to be submitted in writing and will become part of the file. Telephone information will not be accepted in place of written documentation. The Department may conduct additional investigation of irregular information contained in the file or documentation by contacting primary sources or other agencies as necessary to verify application information. Primary source documentation must be original, FAXed documents will not be accepted.

Applications and fees are to be sent to:

Department of Health
Board of Osteopathic Medicine & Surgery
P.O. Box 1099
Olympia, WA 98507-1099

All other inquiries and documents should be directed to:

Department of Health
Board of Osteopathic Medicine & Surgery
P.O. Box 47869
Olympia, WA 98504-7869
(360) 236-4944
(360) 236-2406 Fax

Health Professions Quality Assurance
P.O. Box 47869
Olympia, WA 98504-7869

FEE DATA (All fees are non-refundable)	
☐ Late Renewal Penalty Fee	_____
☐ Current Renewal Fee	_____
☐ Substance Abuse Monitoring	_____
☐ Expired Credential Reissuance Fee	_____

Credential #

Application For Inactive Osteopathic Physician and Surgeon Credential Activation

Please Type or Print Clearly—Follow carefully all instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

All applications must be accompanied by the applicable fee. Make remittance payable to the Department of Health.

1. Demographic Information

APPLICANT'S NAME LAST	FIRST	MIDDLE INITIAL

RESIDENTIAL ADDRESS

CITY	STATE	ZIP	COUNTY

NOTE: Your credentialing document will show this address and all correspondence from the Department will be sent to this address until you notify us in writing of a change. Pursuant to WAC 246-12-310, it is your responsibility to maintain a current mailing address on file with the Department.

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL BUSINESS** HOURS.)	SOCIAL SECURITY NUMBER (**Required** for license under 42 USC 666 and Chapter 26.23 RCW)
( )	— —

GENDER	BIRTHDATE (MO/DAY/YEAR)	PLACE OF BIRTH (CITY/STATE)
☐ Female ☐ Male	/ /	

Have you ever been known under any other name(s)? ☐ Yes ☐ No

If yes, list other name(s):

2. Previous Credentialing **(Since Last Being Credentialed in Washington State)**

STATE/JURISDICTION	PROFESSION	CREDENTIAL			METHOD OF CREDENTIALING	CURRENTLY IN FORCE
		TYPE	YEAR ISSUED	NUMBER		
						☐ NO ☐ YES
						☐ NO ☐ YES
						☐ NO ☐ YES
						☐ NO ☐ YES

3. Professional Experience **(Since Last Being Credentialed in Washington State)**

NATURE OF EXPERIENCE OR PRACTICE AND LOCATION	DATES OF EXPERIENCE	
	FROM (MO/YR)	TO (MO/YR)

4. AIDS Education and Training Attestation

I certify I have completed the minimum of seven (7) hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS

5. Disciplinary Action Attestation

I certify that no action has been taken by any state or federal jurisdiction or hospital, which would prevent or restrict my right to practice my profession.

I further certify that I have not voluntarily given up any credential or privilege or have not been restricted in the practice of my profession in lieu of or to avoid formal action.

APPLICANT'S INITIALS

6. Continuing Education/Continuing Competency Attestation **(If Applicable)**

I certify that I have met all continuing education and competency requirements for the past two (2) years. I am enclosing documentation on all classes attended/claimed.

APPLICANT'S INITIALS

7. Hospital Privileges

List hospitals and locations where privileges have been granted within the past five (5) years.
(Attach additional 8 1/2 x 11 sheets if necessary.)

NAME OF HOSPITAL AND LOCATION	ATTENDANCE	
	FROM (mo/yr)	TO (mo/yr)

8. Applicant's Attestation

I, _____, certify that I am the person described and identified in this
NAME OF APPLICANT

application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state and federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.

_____
SIGNATURE OF APPLICANT

_____
DATE

Official Use Only

Washington State Records Center

Washington State Department of Health
Board of Osteopathic Medicine and Surgery
P.O. Box 47869
Olympia, WA 98504-7869
(360) 236-4944

Hospital Investigative Letter

NAME OF APPLICANT (Please Print) _____ BIRTHDATE (MONTH/DAY/YEAR) _____

I have applied for a license to practice osteopathic medicine and surgery in the state of Washington. Before my request for a license can be reviewed, a background investigation must be completed. Please complete the following questionnaire relative to my hospital privileges and return it directly to:

Department of Health
Board of Osteopathic Medicine and Surgery
PO Box 47869
Olympia, Washington 98504-7869
(360) 236-4944

Please reply as soon as possible to avoid delays in the licensing process.

I hereby authorize you to release the following information to the Washington State Board of Osteopathic Medicine and Surgery.

SIGNATURE OF APPLICANT _____ DATE _____

1. Does the applicant have, or has he/she ever had admitting or specialty privileges at your hospital? ☐ Yes ☐ No

   Beginning Date _____ Ending Date _____

2. Have the applicant's privileges ever been restricted, suspended or revoked by the medical staff or administration, or has he/she ever been asked to resign? ☐ Yes ☐ No

   If so, for what reason _____

   _____

   _____

3. Is there any information in your files that could call into question the applicant's ability to safely practice osteopathic medicine and surgery? ☐ Yes ☐ No

   If yes, please explain _____

Please attach any copies of information in your records that would provide further information.

Name _____

Title _____

Facility _____

Address _____

_____

Telephone Number _____

Authorized Signature _____

Date _____

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Board of Osteopathic Medicine and Surgery
P.O. Box 47869
Olympia, WA 98504-7869
(360) 236-4944

State Licensure Investigative Letter

NAME OF APPLICANT (Please Print) _____ BIRTHDATE (MONTH/DAY/YEAR) _____

I have applied for a license to practice osteopathic medicine and surgery in the state of Washington. Before my request for a license can be reviewed, a background investigation must be completed. Please complete the following questionnaire relative to my state licensure and return it directly to:

Department of Health
Board of Osteopathic Medicine and Surgery
PO Box 47869
Olympia, Washington 98504-7869
(360) 236-4944

Please reply as soon as possible to avoid delays in the licensing process.

I hereby authorize you to release the following information to the Washington State Board of Osteopathic Medicine and Surgery.

SIGNATURE OF APPLICANT _____ DATE _____

To assist the Washington State Board in evaluating the above osteopathic physician's application, we would appreciate receiving the following information.

License Number _____ Date license was issued _____

Status of License: ☐ Active ☐ Military ☐ Other _____
☐ Inactive ☐ Expired

Has the applicant's license ever been suspended or revoked? ☐ Yes ☐ No

Has any other disciplinary or corrective active been taken? ☐ Yes ☐ No

Has the licensee surrendered the license in lieu of disciplinary action? ☐ Yes ☐ No

If you have answered Yes to any of the questions above, attach supporting documentation pertaining to disciplinary orders or any other actions.

State Seal

State Board _____

Address _____

_____

Telephone Number _____

Authorized Signature _____

Date _____